IN THE
SUPREME COURT OF THE UNITED STATES

Nos. 79-4, 79-5, and 79-491

October Term 1979

JASPER F.WILLIAMS AND EUGENE F. DIAMOND,
Appellants
v.
DAVID ZBARAZ, ET AL.,
Appellees

JEFFREY C. MILLER,
Acting Director, Illinois Department of
Public Aid,
Appellant
v.
DAVID ZBARAZ, ET. AL.,
Appellees

THE UNITED STATES OF AMERICA,
Appellant
v.
DAVID ZBARAZ, ET. AL.,
Appellees

ON APPEAL FROM THE U.S. DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS AND THE STATES OF MISSOURI, STATE OF NEBRASKA, AND THE STATE OF OHIO

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INTEREST OF THE AMICI

The Commonwealth of Massachusetts and the States

of Missouri, Nebraska, and Ohio (the amici states) file this amicus brief in support of the appeals of the State of Illinois, et al., from the judgments of the Court of Appeals for the Seventh Circuit and the United States District Court for the Northern District of Illinois. The amici states seek to express their concern that the Court not permit the structure and operation of the state-federal Medicaid program, in which they participate along with Illinois, to be drastically altered by judicial decision unsupported by statutory requirement. In particular, they seek to demonstrate that the decision of the Court of Appeals holding Illinois' state plan for medical assistance to be in conflict with the provisions of title XIX of the Social Security Act disregards established approaches to statutory interpretation and would, if accepted, impose unanticipated burdens and restrictions upon the states. As those who must bear these burdens and adjust to these restrictions, the amici states are perhaps uniquely qualified to convey these concerns to the Court.

SUMMARY OF ARGUMENT

In the first portion of their argument, the amici states place the decision of the Court of Appeals for the Seventh Circuit on the statutory issues in this case, reported as Zbaraz v. Quern at 596 F.2d 196 (7th Cir. 1979), in the context of the litigation under title XIX which has followed this Court's decision in Beal v. Doe, 432 U.S. 438 (1977). The amici states point out that, although the Court of Appeals correctly decided that title XIX does not require participating states to provide reimbursement for costs related to the provision of so-called "medically necessary" health care services, including abortion services, the court erroneously concluded that Illinois' plan for medical assistance, despite the effect of the so-called Hyde Amendment, [1] does not conform to the requirements of title XIX.

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[1] The amici states limit their argument in this brief to the statutory issues this case involves, in particular to the question of title XIX's proper interpretation. They do not consider the effect of the Hyde Amendment, for, in their view, there is no need to do so once title XIX's requirements are properly understood.

The Hyde Amendment applicable to the proceedings in the Court of Appeals is a limitation on appropriations for the Department of Health, Education, and Welfare andprovides in pertinent part that:

(footnote continued)

The amici states dedicate the second portion of their argument to a review of title XIX's controversial "necessary medical services" language. The meaning of this phrase is critical to the reasoning of the Court of Appeals in this case, reasoning which the appellees may well challenge in this Court. What Congress meant by the phrase is also generally misunderstood. To demonstrate the fundamental nature of this misunderstanding and provide the Court with a basis for affirming the "medically necessary" aspect of the decision of the Court of Appeals, the amici states present a careful analysis of title XIX's legislative history. This analysis demonstrates that Congress did not use the phrase "necessary medical services" as a substitute for the term "medically

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(footnote continued)

> provided, That none of the funds contained in this Act shall be used to perform abortions except when the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service, or except in those instances where severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Zbaraz v. Quern, 596 F.2d at 199.

necessary" services and that the Court of Appeals correctly concluded that title XIX does not require the states to reimburse health care providers for costs related to the provision of "medically necessary" health care services.

Finally, the amici states conclude their argument with a review of title XIX's conformity criteria, including those provisions upon which the Court of Appeals relied to hold Illinois' state plan inconsistent with the statute. The amici states once again emphasize the importance of careful statutory analysis to the preservation of the complicated structure of federal-state relations which provides the foundation for the Act's various public assistance programs.

ARGUMENT

I. The Nature Of The Problem

Must a state provide reimbursement for the costs of a particular "medically necessary" health care service under its Medicaid program? If not, is it yet "unreasonable and wholly inconsistent with the purposes of title XIX" for a state not to do so? These two questions embody the essence of a number of cases pending in various postures in lower federal courts throughout the country. In large part, these cases are the successors to Beal v. Doe, 432 U.S. 438 (1977), in which this court held that title XIX of the Social Security Act does not impose upon states which choose to participate in the cooperative federal-state program of medical assistance which it authorizes an obligation to reimburse health care providers for the costs of "elective" health care services not included in a state's approved plan for medical assistance. In reaching this conclusion, the Court, as it had in earlier A.F.D.C. cases, [2/] stressed that the question involved was one of statutory interpretation and set forth an analytical model which, one might have supposed, lower courts would recognize as the one to use when called upon to resolve similar controversies. Unfortunately, with a few encouraging

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2/ E.g., Burns v. Alcala, 420 U.S. 575 (1975).

exceptions, the lower federal courts have failed to adopt this Court's approach to the interpretation of title XIX's provisions and, instead, reached decisions imposing requirements upon the states which lack support in the statute's provisions and any resemblance to the analytical methodology used in Beal.[3/] These cases, often, as in this one, involving state limitations on the reimbursement of costs related to the provision of so-called "medically necessary" abortion services, pose significant problems for participating states because the breadth of the principles involved threaten to constrict significantly the states' traditional ability to determine the type

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3/ While Beal's status as a model of analysis is well-deserved, it does contain an unfortunate element of commentary which is largely responsible for the present controversy over "medically necessary" services. The troublesome dictum appears near the end of the Court's analysis of the statutory issue: "Although serious statutory questions might be presented if a state medicaid plan excluded medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary — though perhaps desirable — medical services. . . [emphasis supplied and in the original]." 432 U.S. at 444-45.

This dictum has led many lower courts to assume an admittedly serious question has an even more serious answer, i.e., that title XIX does require states to pay for "medically necessary" services. A major portion of the argument contained in this brief is devoted to demonstrating the opposite. See pp. 10-30, below.

and amount of benefits coverage available under their individual plans for medical assistance.

In this brief the amici states seek to persuade the Court that: (1) the Court of Appeals for the Seventh Circuit in this case properly followed the decision of the Court of Appeals for the First Circuit in Preterm v. Dukakis, 591 F.2d 121 (1st Cir. 1979) and determinined that title XIX of the Social Security Act (Act) does not require states participating in the Medicaid program to provide reimbursement to health care providers for costs related to the provision of any particular "medically necessary" health care service, including abortion services; and (2) that both the Court of Appeals for the Seventh Circuit in this case and the Court of Appeals for the First Circuit in Preterm v. Dukakis, supra, incorrectly concluded that a state's failure to include a provision authorizing the reimbursement of costs related to the provision of "medically necessary" abortion services in its state plan for medical assistance "violate[s] the purposes of the Act and discriminate[s] in a proscribed fashion. . . .," Zbaraz v. Quern, 596 F.2d 196, 199 (7th Cir. 1979), citing Preterm v. Dukakis, supra. The approach to this task which the amici states have chosen is to begin with a detailed review of title XIX's legislative history, particularly that associated with the use of the phrase "necessary medical

service." This review demonstrates that the Court of Appeals properly held that title XIX does not require Illinois to provide reimbursement for costs related to the provision of "medically necessary" abortion services. The amici states conclude their argument by demonstrating that state plans for medical assistance such as those of Illinois and the amici states which place various restrictions on the reimbursement of costs related to the provision of "medically necessary" abortion and other services are not "'unreasonable'" and wholly '[in] consistent with the objectives of the Act. . . .,'" Preterm v. Dukakis, 591 F.2d at 126, but rather conform to the requirements of title XIX.

II. Title XIX Does Not Require Participating States To Provide Reimbursement For The Costs of Any Particular "Medically Necessary" Service.

A. Introduction

Proper interpretation of the Social Security Act depends upon careful observation of its architecture. Although Congress has amended the statute often and substantially since its passage in 1935, its basic structure has exhibited remarkable endurance. Title XIX of the Act (Medicaid), codified as Chapter XII, subchapter XIX, §§ 1396a-1396k of the United States Code, follows closely the now classic style of the Act's draftsmen: Section 1901 (codified as 42 U.S.C. § 1396 (1976)) constitutes an appropriations authorization and embodies a subsidiary statement of purpose; section 1902 (codified as 42 U.S.C. § 1396a (1976)) establishes state plan requirements and directs the Secretary of Health, Education, and Welfare to approve plans which meet these requirements; section 1903 (codified as 42 U.S.C. § 1396b (1976)) requires the Secretary to reimburse states for certain portions of their expenditures "as medical assistance"; section 1904 (codified as 42 U.S.C. § 1396c (1976)) authorizes the Secretary of HEW to suspend payments after notice and hearing (the so-called "conformity hearing") upon a

determination that a state has affected unlawful modifications in its state plan or has failed to administer it in substantial compliance with the state plan requirements contained in § 1902; section 1905 (codified as 42 U.S.C. § 1396d (1976)) provides definitions of selected terms, including and of particular importance for present purposes, "medical assistance"; and the remaining sections deal with miscellaneous matters, including criminal penalties for fraudulent claims, the certification of skilled nursing home facilities, and similar specific aspects of the Medicaid program.[4/]

Section 1901 provides, as it did when originally enacted in 1965 that:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of

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4/ A common short-hand way of referring to the major or original sections of the Act when one is concerned with their function regardless of the programmatic title in which they appear is by their last two digits (the first digit merely identifies the title). Thus, whatever the title, §§ 102, 402, etc. (the state plan requirements sections) are referred to as the "02" sections, §§ 103, 403, etc. (the payments to the state sections) as the "03" sections; and §§ 104, 404, etc. (the conformity hearing sections) as the "04" sections. The amici states also use this method of reference occasionally in this portion of their brief.

families with dependent children and of aged, blind, or disabled[5/] individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

Four features of this section merit close attention. First, it is primarily an appropriations authorization and subsidiary statement of purpose section. Second, the section in terms imposes no substantive requirements upon the states. Rather, in its only sentence which can fairly be considered prescriptive, it simply restricts the use of the funds it authorizes to be appropriated each

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5/ 87 Stat. 960 substituted the term "disabled" for the phrase "permanently and totally disabled."

fiscal year to the making of payments to those states which have submitted "plans for medical assistance" to the Secretary of HEW and obtained the requisite approval of them. Third, as do the cognate sections of its predecessors and successors,[6/] the section begins with a statement of purpose which announces Congress's intention as being to "[enable] each State, as far as practicable under the conditions in such State, to furnish. . . [emphasis supplied]" a certain type of public assistance ("medical assistance") to certain persons. Recognition of the financial limitations of state governments is clearly this language's purpose. Fourth and perhaps most importantly, the section never uses the phrase "medically necessary." Congress's omission of any reference to this concept in the design and construction of this section is, as the amici states argue later, quite intentional, and judicial attempts to conflate the phrase "necessary medical services" with the term "medically necessary" not only lack textual support but also do violence to the statute's architecture.

Section 1901 has two—and only two—functions to perform as a component of title XIX, and Congress designed it to perform these functions in concert with three other sections: 1902, 1903, and 1905. The first

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6/ E.g., titles I and XX.

function is to operate as a standing authorization for appropriations. It performs this function in conjunction with § 1903 which requires the Secretary to pay each state with an approved plan from appropriated funds "an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (e), and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan. . . ."

The second function is to limit the use of appropriated funds to the reimbursement of only those state expenditures incurred as "medical assistance provided to eligible persons." Since "medical assistance" is a defined term, see § 1905(a), analysis of the relationship between the "01" section and its mention of "necessary medical services" and the definition contained in the "05" section requires a somewhat lengthy digression.

B. Federal Financial Participation In State Expenditures For Health Services Prior To The Enactment Of Title XIX

Title XIX, enacted in 1965, created a separate system for providing medical assistance benefits to persons who previously received such benefits as a function of their eligibility for the more traditional form of public assistance: cash grants. For example, under title I

(originally Old-Age Assistance (OAA)), federal financial participation was available to states in "an amount, which shall be used exclusively as old-age assistance, equal to one-half of the total of sums expended. . . as old-age assistance under the State plan. . . ," 49 Stat. 621, § 3(a). This traditional cash grant form of public assistance was expanded in 1956 to include "medical assistance" and a medical "vendor payments" program. Although states had previously been able to assist OAA recipients in meeting medical expenses and obtain federal financial participation in the expenditures they incurred, they had been limited to providing this assistance as part of the monthly OAA cash grant, and rather low limits were placed on the maximum amount of a cash grant. As the Senate Finance Committee noted:

> The bill would provide Federal matching of expenditures for payments to suppliers [vendors] of medical care separate from money payments to assistance recipients and would use an average basis for determining Federal participation in payment to suppliers of medical care . . . . This assurance of Federal participation on an average basis should stimulate States to secure necessary care for recipients, particularly in States with relatively

> limited resources . . . . Under the bill all payments to suppliers of medical care would be matched under the separate provision. States would still be able if they chose to do so to include in money payments to recipients amounts to meet medical needs within the maximums on money payments specified in titles I, IV, X, and XIV . . . [emphasis supplied].
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> Sen. Rept. No. 2133, 84th Cong., 2nd Sess., July 26, 1956, reprinted in 3 U.S. Code Cong. & Admin. News 3877, 3905-06 (1956).

Two specific points are worth making at this juncture. First, the Congress, as it usually does when it improves the Social Security Act, expressed its intention in terms of "stimulating" — not requiring — the states to increase their expenditures for public assistance and recognized that, given the fiscal limitations of state governments, the most effective form of stimulation is increased federal financial participation. Second, this is the first time that the word "necessary" appears, as far as the amici states are aware, in conjunction with a discussion of medical care benefits. Significantly, the word does not appear in the 1956 amendments themselves.

Moving forward in time, one learns that the Social Security Amendments of 1960 worked the penultimate

significant change in Congress's approach to authorizing federal financial participation in state expenditures for medical care under the Act's public assistance programs. Often referred to in part as the Kerr-Mills Act, portions of the 1960 Amendments were the predecessor of title XVIII (Medicare) and, as events unfolded, title XIX as well. Noting that "[t]he major issue presented to the [Senate Finance Committee] this year has been the increasing cost of adequate medical care for older people . . . ," the Senate Finance Committee proposed substantial changes in the House bill, H.R. 12580. For present purposes, the most significant change was to provide for the amendment of title I to include "medical services for the aged," and the most illuminating aspect of these amendments is the legislative history associated with the introduction of the phrase "necessary medical services." As a review of this material demonstrates, the lower federal courts have erred in reasoning that Congress used the phrase "necessary medical services" as an equivalent for the term "medically necessary" in title XIX. To the contrary, when it used the phrase "necessary medical services" for the first time in 1960, Congress had a completely different concept and purpose in mind.

The Senate Finance Committee's report accompanying the 1960 Amendments and referring specifically to the Kerr-Mills Act amendments to title I

of the Act begins its analysis with the following instructive paragraph:

> Your committee has designed a Federal-State matching program based upon historic principles of Federal-State cooperation. This program is established under title I of the Social Security Act, thereby providing additional matching funds to the States to (1) establish a new or improve their existing medical care program for those on the old-age assistance roles, and (2) add a new program designated to furnish medical assistance to those needy elderly citizens who are not eligible for old-age assistance but who are financially unable to pay for the medical and hospital care needed to preserve their health and prolong their life. The twofold plan would thus cover all medically needy aged 65 or over, whether or not they are eligible for old-age assistance, or whether or not they are eligible for the benefits under the social security or any other retirement program. It accomplishes this objective within the framework of a Federal-State program with broad discrimination allowed to the States as to the programs they will institute, improve, and administer

> in meeting the health needs of the aged when illness occurs or continues [emphasis supplied].7/

Sen. Rept. No. 1856, 86th Cong., 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3608, 3610 (1960).

The report continues with a description of title I's

7/ The report contains a further and more explicit statement of purpose which is also worth reading:

> 1. Purpose
>
> The existing provisions of title I provide Federal funds to the States for medical services to aged individuals who are determined to be needy by the States. At the present time, States provide needy aged person with "money payments" for medical services and also provide "vendor payments" to the suppliers of medical care . . . . These provisions vary greatly. Some States have relatively adequate provisions for the medical care of needy persons; others have little or no provision. The increased Federal financial provisions in the bill are designed to encourage the States to extend comprehensive medical services to all needy persons receiving monthly assistance payments. Participation in the Federal-State program is completely optional with the States, with each State determining the extent and character of its own program, including the standards of eligibility and the nature and scope of benefits. The limits of Federal financial participation are discussed later in this report [emphasis supplied].

operation prior to amendment and the changes which the Committee intended to make in it. Although too lengthy to reproduce in their entirety here, certain sections deserve explicit mention. The report makes clear that Congress's intention was to "encourage," not require, the states to enlarge their expenditures for medical care services provided to persons receiving OAA or who, while able to meet the day to day expenses of life, are unable to incur substantial expenditures for medical services (the "medically needy"). While the Congressional goal was to encourage the development of "comprehensive medical care program[s]" for OAA recipients, the Senate Finance Committee deliberately wrote that, as to the scope of medical services the states might provide and still secure federal financial participation in their OAA expenditures, "[t]here is no Federal limitation on medical services provided under the bill. Each State may determine for itself the scope of medical services to be provided in its program." Similarly, as to the "medically needy" and the new Medical Assistance for the Aged (MAA) program, the Committee emphasized the incentive nature of its proposal and its intention that the states:

> have broad latitude in determining eligibility for benefits under the program as well as the scope and nature of the services to be provided within the limitations prescribed. Thus, each State

> would determine the tests for eligibility and the medical services to be provided under the State program within the limitations described below. Federal financial participation would be governed by the establishment of an approved plan subject to the criteria and limitations prescribed in the law [emphasis supplied].

The limitations upon federal financial participation to which the Committee referred are listed in the immediately following section of the report which deals with eligibility:

> 2. Eligibility
> Benefits under a State program may be provided only for persons 65 years of age or over to the extent they are unable to pay the cost of their medical expenses . . . [emphasis supplied].

And then the Committee indicated exactly how it proposed to amend title I to accomplish its goals:

> Section 1 of the Social Security Act, as it would be amended by the bill, provides that one of the objectives of the title is to furnish medical assistance to individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet

the costs of necessary medical services. . . [emphasis supplied] .8/

Here, then, are the roots of the phrase "necessary medical services" which some lower federal courts equate with the term "medically necessary." These roots rest not in the "02" plan requirements section of title I, but rather in the "01" authorization section. They are nurtured not by a Congressional intention to require the States to provide any medical services at all, "medically necessary" or otherwise, but rather by a desire to limit the availability of MAA program benefits to those medically needy aged persons "whose income and resources are insufficient to meet the cost of necessary medical services [emphasis supplied]." Unless the Congress substantially altered its intentions between 1960 and 1965 concerning the federal-state public assistance programs and their medical services components which it created under the Act, the amici states submit that it should be clear that the phrase "necessary medical services," and the legal purpose it was intended to serve, are not equivalent — indeed, have nothing in common with — the term "medically necessary." The following discussion

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8/ The Conference Committee adopted the Senate Finance Committee's approach and its choice of the phrase "necessary medical services." Conf. Rept. No. 2165, 86th Cong., 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3749, 3756 (1960).

both brings this digression to a conclusion and demonstrates that the Congress made no such change in its intentions when it enacted title XIX.

C. The Enactment of Title XIX

Title XIX was enacted as a component of the Social Security Amendments of 1965, 79 Stat. 286. Title XVIII, which created the Medicare program, was the major provision of this set of amendments to the Act, and the controversial nature of this initial national foray into health insurance overshadowed the issues involved in the drafting of title XIX. This result is understandable for, as the Congress conceived it, title XIX was simply a consolidation and improvement of the existing medical assistance programs already authorized under the Act's various categorical assistance titles. The Senate Finance Committee's report makes this point clear:

6. BACKGROUND AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided.

Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of needy aged, blind, disabled, and dependent children — the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs [i.e., "necessary medical services"] . . . .

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the

> committee bill would establish, effective January 1, 1966, a new title in the Social Security Act - "Title XIX: Grants to the States for Medical Assistance Programs."
>
> Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2014.9/

The Senate report then goes on at some length and in fair detail to describe the general nature of its proposals for title XIX and, in a section by section analysis, the effect of the proposal's specific provisions. See Sen. Rept. 404, 89th Cong., 1st Sess. (1965), reprinted in U.S. Code Cong. & Admin. News, 2015-52 (1965). Three observations are worth making concerning the report's contents. First, it specifically discusses suggested state plan requirements for inclusion in the "02" section of the new title. Second, neither in its discussion of plan requirements nor anywhere else does the report mention the term

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9/ The introductory summary of the proposed title XIX put the matter even more simply:

> In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to consolidate and expand the differing provisions for the needy which currently are found in five titles of the Social Security Act.

"medically necessary" or suggest that the Senate Finance Committee intended to require the States to provide any specific type of medical services. Rather, as stated in the paragraphs dealing with eligibility and in reference to the "02" section requirements, the committee spoke only in terms of requiring states to include in their state plans "provision for medical assistance [to the categorically eligible and, if desired, the "medically needy"]," id. at 2017; see also 2144-45. Third, § 1901 was taken, with appropriate adjustments to make its provisions applicable to all of the Act's categorical assistance titles, from § 101, as amended by the Kerr-Mills Act in 1960. See id. at 2144.

And so, there it is. The relationship between "necessary medical services" and the defined term "medical assistance," the relationship which prompted this extended digression, now appears to be a straight-forward one. "Necessary medical services" is the phrase, inherited from Kerr-Mills, which the Congress used first in Kerr-Mills and then in title XIX both to (1) expand the availability of federal financial participation beyond the categorically needy to the medically needy and (2) limit the federal obligation to participate in state expenditures to those incurred as "medical assistance" on behalf of persons "whose income and resources are insufficient to meet the costs of necessary medical services. . . [emphasis supplied]." "Medical assistance," defined as usual in the "05" section of the new title, imposes

the substantive requirement through its use, as usual, in the "02" section. Neither phrase has anything to do with the concept to which the term "medically necessary" refers.[10/]

D. The Use of the Defined Term "Medical Assistance"

Observation of title XIX's architecture reasonably concludes with a moment's look at the detailing associated with the placement and use of the defined

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10/ The Court should understand that the concept to which the term "medically necessary" refers is intrinsically judgmental. It amounts, in effect, to the clinical judgment of a physician that a certain course of treatment is required. Obviously, such judgments vary widely. See Preterm v. Dukakis, 591 F.2d at 125. To be sure, the Congress has established special entities under title XI of the Act, i.e., Professional Standards Review Organizations or PSROs, to review the appropriateness of health care services provided to Medicaid recipients by participating providers. These entities are empowered to disallow provider claims for reimbursement under a state Medicaid program only if they determine that the health care services provided were unnecessary or otherwise inappropriate. 42 U.S.C. § 1320c-4 (1976). However, there is no question that many types of health care services may pass scrutiny under the "medically necessary" test within the meaning of title XI's PSRO provisions but nevertheless lawfully be subject to exclusion by a state from its state plan for medical assistance for fiscal or other permissible reasons. In short, the Act's PSRO provisions are designed to protect the federal and state treasuries and not to force the expenditure of state funds.

term "medical assistance." As it appears in the "05" section, the definition of "medical assistance" contains no mention of "medically necessary" health care services. Indeed, it mentions no specific type of health care service or characteristic of a health care service. Rather, it refers to broad classes or categories of health care and services and defines "medical assistance" to mean "payment of all or part of the cost of the following care or services . . . [emphasis supplied]." 42 U.S.C. §1396d(a) (1976). This choice of form, as with most architecture, is based upon a clear perception of function:[11/] to describe the type of state expenditure in which the federal government would be willing to participate while leaving to the states broad discretion to determine the exact nature of the benefits to provide eligible recipients.

E. Summary

Title XIX's structural lines have not changed significantly since Congress shaped them in 1965. While both Congress and the Department of Health, Education, and Welfare have made substantial additions to the basic structure over the past fifteen years, most noticeably in

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11/ See generally L. Sullivan, The Tall Office Building Artistically Considered, Lippencott's Magazine (March, 1896) (containing the statement thought to guide modern architecture that "Form ever follows function").

the areas of cost control and facility and service standards, the amici states have found no indication of an intention to alter the title's fundamental design principles, principles which rest upon the foundation which the Congress erected in 1935: (1) a federal-state cooperative system of financial participation in state expenditures for public assistance which (2) recognizes the historic and primary role of the states in the social welfare area and (3) seeks to stimulate and encourage the improvement of state welfare programs by making federal financial participation available to states which (4) submit plans for public assistance programs to the Secretary of HEW which satisfy the Act's requirements. A well-designed statutory scheme such as this cannot reasonably be thought to have omitted from careful and explicit statment such an essential requirement as some lower federal courts in cases similar to this have added to it. Rather, as the argument in the following section demonstrates, the Court should judge the conformity of Illinois' state plan for medical assistance on the basis of title XIX's explicit standards, standards which include neither a requirement that states reimburse health care providers for costs related to the provision of "medically necessary" abortion services nor provisions which render non-conforming as "unreasonable" or "inconsistent" a state plan which excludes such services.

III. Title XIX Contains Explicit Standards For Judging The Conformity Of A State Plan With Federal Requirements, And These Standards Do Not Require State Plans To Include Provisions Authorizing The Reimbursement Of Costs Related To The Provision Of "Medically Necessary" Abortion Services.

Title XIX in its "04" section provides as usual that, if the Secretary of HEW determines after a conformity hearing that a previously approved state plan no longer complies with the requirements of the "02" section or is being administered in a manner which does not "comply substantially" with "02" requirements, she shall stop making payments as federal financial participation to the non-conforming state. The "04" section thus makes clear Congress's intention that federal funds appropriated under title XIX not be available as federal financial participation to states whose "plan[s] for medical assistance," although once properly approved, are altered or administered in a manner such that the programs they authorize no longer "comply substantially" with the provisions of §1902. See Woodruff v. Lavine, 417 F. Supp. 824 (S.D.N.Y. 1976) (standard of judicial review of state compliance with Early and Periodic Screening, Diagnosis, and Treatment program component of the Medicaid

program is "substantial compliance").[12/] Therefore, the focus of a conformity examination, whether before HEW or, as here, in the federal courts, must be on the requirements of the "02" section.[13/] A concurrent look at title XIX's "02" section and several leading cases should establish that, while §1902 includes many conformity criteria, the restrictions which the Court of Appeals imposed in this case (amounting to a determination that, despite the effect of the Hyde Amendment, Illinois must include a plan provision authorizing payment for all "medically necessary" abortions, Quern v. Zbaraz, 596 F.2d at 199, are not among them.

The traditional opening sub-section of an "02"

12/ In Rosado v. Wyman, 397 U.S. 397 (1970), this Court held that the availability of an administrative procedure under the "04" sections of the Act does not bar a federal district court from reviewing a claim of non-conformity brought by a person eligible for assistance under the Act. Id. at 406.

13/ Over the years, the Congress has taken a somewhat eclectic attitude toward the design of additions to the Act, and one occasionally finds requirements imposed upon the states in sections other than "02". However, with the exception of the "necessary medical services" language contained in title XIX's "01" section, the Court of Appeals did not conclude that a section other than "02" (and its regulations) is involved in this case.

provision in the Social Security Act begins with the statement that "A State plan for the [the appropriate type of public assistance] must— . . . ," and title XIX's "02" section, § 1902, follows this tradition. Beginning with the established introduction, § 1902(a) goes on to impose a set of requirements which the amici states readily concede participating states must satisfy if they are to obtain federal financial participation in their expenditures as medical assistance.[14/] Not one of these explicit requirements mentions the term "medically necessary" although many of the forty sub-divisions are extremely precise in their language and deal with quite narrow problems.[15/] The amici states submit that the proper conclusion on the basis of this observation is that the Court of Appeals erroneously determined that the Congress intended to prohibit Illinois from refusing to provide reimbursement of costs related to the provision of some "medically necessary" abortion services.

To be sure, this conclusion does not mean that states are free to design state plans without regard to any

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14/ As originally enacted in 1965, this list numbered twenty-two; it now reaches forty, not including two additional and recently added unnumbered paragraphs.

15/ E.g., (16), (18), (25), & (32).

minimal federal benefits requirements. To the contrary, the amici states candidly admit that title XIX's "02" section does impose certain and definite standards against which the Secretary of HEW and the federal courts are to judge the adequacy of a state plan's benefits provisions. None of these standards, however, justifies the restrictions which the Court of Appeals would impose on Illinois.

As title XIX's legislative history makes clear, seven of the "02" sections' original requirements are "standard" provisions "which are either identical to the existing provision of law or are merely conforming changes . . . ." Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2014 (1965).[16/] The Congress added several more provisions to these "standard" provisions "which are either new or changed over provisions currently in the law . . . ." Id. at 2015.[17/] Of these provisions, three

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16/ These requirements appear in the current version of § 1902 as sub-divisions (1), (3), (6), (7), (8), (12), and (16).

17/ These additions appear in the current version of § 1902 as sub-divisions (2), (4), a provision found in other titles of the Act but slightly modified for title XIX's purposes, (5), (9), (10), (11), (13), (14), (15), (17), (18), (19), (20), (21), and (22). Many of these provision, including two of the three most important to the question before the (footnote continued)

provide the criteria against which the conformity of a state plan amendment like that which Illinois adopted should be judged: (10), (13), and (17).

Sub-division (10)[18/] has three critical functions:

(footnote continued)

Court, i.e., (13) and (17), are based upon similar or identical provisions found in the Act's other categorical assistance titles, particularly title I, as amended in 1960 by the Kerr-Mills Act. This point is discussed in the immediately following text.

18/ In its current form, sub-division (10) provides that:

(10) Provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(footnote continued)

first, to require participating states to provide "medical assistance" to all persons categorically eligible for benefits under the Act's other public assistance titles;

(footnote 18 continued)

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical

(footnote continued)

second, to permit states to extend medical assistance to the medically agreement entered into under needy; and, third, to prohibit state plans from discriminating in the amount, scope, or duration of medical assistance among categorically eligible individuals or medically needy individuals or between individuals in the categorically eligible class and individuals in the medically needy class.[19/] As the Court of Appeals implicitly

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(footnote 18 continued)

insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such paragraph, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A). . . .

recognized, sub-division (10) merely contains a rule of consistency or even-handedness designed to prevent certain undesirable patterns of plan administration from developing.[20/]

Sub-division (13), in its original form, was derived from title I, § 2(a)(11), as added by the Kerr-Mills Act,[21/] and, with respect to the categorically

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19/ This provision appears to be derived in concept from title I, as amended by the Kerr-Mills Act to include the "medically needy," and HEW's generic anti-discrimination policy, generally referred to as "Regulation X." See generally Note, Welfare's "Condition X," 76 Yale L.J. 1222 (1967). The legislative history is reproduced in 1 U.S. Code Cong. & Admin. News, 1943, 2017.

20/ The previous discussion of the derivation of the phrase "necessary medical services" applies to its use in sub-section (10).

21/ Amendments to sub-division (13) since 1965 have not altered the provisions important for present purposes. Presently, sub-division (13) provides that:

(13) provide—

(A)(i) for the inclusion of some institutional and some non-institutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(footnote continued)

eligible,[22/] imposes the following definite requirements upon state plans:

(footnote 21 continued)

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title, I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplementary security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section § 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of apporoval by the Secretary) included in the plan,

(footnote continued)

(13) provide—

(A)(i) for the inclusion of some institutional and some non-institutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing

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(footnote 21 continued)

except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

(F) for payment of services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribed in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph . . . .

facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplementary security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section § 1905(a) [the definition of "medical assistance"] . . .[emphasis supplied].

Sub-paragraph (A)(i) uses particularly significant language, taken verbatim from title I as amended by Kerr-Mills, to state the required scope of a state plan: "some institutional and some non-institutional care and services . . .[emphasis supplied]." The statute doesn't say "all," and it certainly doesn't say "medically necessary." The reason that it says neither of these things is that the Congress had no intention of imposing such a requirement. Rather, title XIX was premised on the same basis as the Kerr-Mills Act and all the other of the Act's public assistance titles: state discretion to determine the scope of benefits included within a state plan.

Paragraph (B)'s provisions do not lead to any different conclusion. This paragraph simply follows the Act's

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22/ The analysis is similar for the medically needy.

traditional approach of relying upon its "05" definitional section to describe and limit the nature of the public assistance within the title's scope, and the "05" language in title XIX is equally direct in its acknowledgment of the states' prerogative to determine the scope of benefits they will offer under their state plans:

> (a) The term "medical assistance" means payment of all or part of the following care and services . . . .
>
> (1) inpatient hospital services . . . ;
>
> (2) (A) outpatient hospital services . . . ;
>
> (3) other laboratory and x-ray services . . . ;
>
> (4) (A) skilled nursing facility services . . . ; [and]
>
> (5) physicians' services, furnished by a physician (as defined in section 1861(r) (1)), whether furnished in the office, in the patient's home, a hospital, a skilled nursing facility, or elsewhere . . . [emphasis supplied].

Two things are clear from this language. First, just as in paragraph (A), states are not required to pay all of the cost of any type of care or service. Second, they are not required to pay the cost of any particular care or service. Rather, one of § 1905(a)'s purposes is satisfied, as far as the categorically eligible are concerned, if a state plan includes provisions which authorize payment of "all or

part" of "some institutional and some non-institutional care and services."[23/] Since a state plan need not include all "care and services," it clearly does not need to include a specific type of surgical service, e.g., abortion services, whether "medically necessary" or not.

Sub-division (17) is the last source of material plan conformity criteria.[24/] The sub-division is lengthy, but its material portion can be set forth:

> (17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving [categorical assistance or SSI], based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title . . . [emphasis supplied].

23/ The legislative history concerning the definition of "medical assistance" is reproduced in 1 U.S. Code Cong. & Admin. News 1943, 2021 (1965).

24/ Some lower federal courts also have thought sub-division (19) important, but its legislative history, discussed below, makes clear that the sub-division's significance lies in other areas.

The essential language of this paragraph, underscored as it is reproduced above, is found in the Kerr-Mills version of title I: "(11)(D) include reasonable standards, consistent with the objectives of this title, for determining eligibility and the extent of such assistance . . . ." 74 Stat. 924. Because the Court of Appeals relied so heavily on sub-division (17), the Senate Finance Committee's comments concerning its predecessor in Kerr-Mills deserve extensive quotation:

> MEDICAL ASSISTANCE FOR THE AGED RECEIVING OLD-AGE ASSISTANCE
>
> 3. Eligibility.
>
> Each State has the responsibility of determining the standard of eligibility for the medical care it provides to aged persons. For aged persons receiving money payments the State must take into consideration any income and resources of the individual.
>
> 4. Scope of medical services.
>
> There is no Federal limitation on medical services provided under the bill. Each State may determine for itself the scope of medical services to be provided in its program.

MEDICAL ASSISTANCE FOR THE AGED NOT RECEIVING OLD-AGE ASSISTANCE [MEDICALLY NEEDY]

1. Purpose.

* * *

A State would have broad latitude in determining eligibility for benefits under the program as well as the scope and nature of the services to be provided within the limitations described below . . . .

2. Eligibility.

* * *

The State has wide latitude to establish the standard of need for medical assistance as long as it is a reasonable standard consistent with the objectives of this title . . . .

3. Scope of benefits.

* * *

The scope of medical benefits and services provided will be determined by the States . . . . [empnasis supplied].

Sen. Rept. No. 1856, reprinted in 2 U.S. Code Cong. & Admin. News 3610-14 (1960).

The legislative history of this provision as Congress enacted it in title XIX in 1965 also deserves attention:

(d) Determination of need for medical assistance

The committee bill would make more explicit a provison now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable to the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them . . . . The bill also contains a provision designed to correct one of the weaknesses identified in the medical asistance for the aged program [title I].

Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual . . . . In order that the States shall be flexible in the consideration of an individual's income, the committee requires that the State's standards for determining eligibility for and the extent of medical assistance shall take into account, except to the extent prescribed by the Secretry, the cost . . . . incurred for medical care or any other type of remedial care recognized under State law . . . [emphasis supplied].

Sen Rept. No. 404, reprinted in 1 U.S. Code Cong. & Admin News 1943, 2018-19.

The truly remarkable learning one gains from this review of sub-division (17)'s legislative history is that the Congress intended (17) to deal primarily with issues of eligibility, not benefits, for it recognized that, under the Act, benefits determinations have always been primarily the states' responsibility. See, e.g., Rosado v. Wyman, 397 U.S. 397, 413 (1970); Bourgeois v. Stevens, 532 F.2d 799, 807 (1st Cir. 1976). Therefore, insofar as the Court determines to look to sub-division (17) as a source of conformity criteria, it should do so realizing that the

decision of the Court of Appeals concerns a benefit, not an eligibility, determination regarding a particular type of surgical service and that, as to such determinations, the Congress has expressed its intention quite clearly that "[t]he scope of medical benefits and services provided will be determined by the States . . . ." Sen. Rept. No. 1856, reprinted in 2 U.S. Code Cong. & Admin. News 3610-14 (1960) (applicable to Kerr-Mills Act and carried over by implication to title XIX). Thus, this section properly understood is not a basis for holding that Illinois' plan for medical assistance, simply because it excludes from benefits the reimbursement of costs related to the provision of certain "medically necessary" abortion services, " 'violate[s] the purposes of the Act and discriminate[s] in a prescribed fashion . . . .' " Zbaraz v. Quern, 596 F.2d at 199, citing Preterm v. Dukakis, 591 F.2d 121, 126 (1st Cir. 1979).

One last provision of title XIX's "02" section, sub-division (19), requires discussion. This sub-division currently provides that:

> (19) provided such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients . . . [emphasis supplied].

Once again, the legislative history of this provision makes the Congressional purpose underlying its enactment clear:

> Under provisions of the committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of care to be provided. The committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and services in order to encourage their full cooperation and participation in the provision of services

> under the State plan . . . [emphasis supplied].
>
> Sen. Rept. No. 404, reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2016-17 (1965).

One finds no mention of an intention to require the states to provide any type of health service benefit in this discussion. Moreover, it is evident that the nature of the concerns with which the committee was dealing is completely unrelated to the concept of "medically necessary" health care services. This Court's previous chastising of the Seventh Circuit for its quickness to infer requirements under the Act without specific authority in its text or legislative history should preclude an argument that sub-division (19) should be interpreted broadly:

> The short answer is that, since § 402(a)(10) on its face applies only to "aid to families with dependent children" and not to the separately designated program of "emergency aid to needy families with children," it cannot be the basis for making § 406(e) eligibility requirements mandatory on the States.
>
> The Court of Appeals recognized that § 402(a)(10) was limited by its language to AFDC, but nevertheless concluded that Congress intended to treat EA "in the same way" because it is "part of the same statutory scheme," and rooted in the "same Congressional concern with the deprivation of children that brought forth

> the AFDC program . . . ." Mandley I, supra, at 422. But Congress' choice of precise language in this complex statute cannot be glossed over with such generalities . . . .
> Quern v. Mandley, 436 U.S. 725, 741 (1978).

The state defendants submit that this review of title XIX's "02" requirements demonstrates that the statute includes a large number of explicit conformity criteria against which the Secretary of HEW and the federal courts should judge a state plan for medical assistance. None of these criteria mentions the phrase "medically necessary," and none, including those which the Court of Appeals relied upon, is even suggestive of an intention on the part of the Congress to restrict the states' well-established, traditional discretion to determine the scope of benefits included in their state plans. Indeed, the terms of the individual provisions of §1902, their inter-relationships within the section, and their legislative history establish that the Congress never considered imposing such a burdensome and fundamentally uncertain requirement as the term "medically necessary" denotes. Nor did Congress implicitly, as the Court of Appeals thought, determine to preclude the states from restricting benefits as Ilinois has done.

In addition to the statutory provisions of sub-section (17), the Court of Appeals and other lower federal courts

have relied upon a regulation, 42 C.F.R. § 449.10(a)(5)(i) (1977)[25/] to support the conclusion that a state must provide reimbursement for the costs of "medically necessary" abortion services. E.g., Zbaraz v. Quern, 596 F.2d at 198-99; Preterm v. Dukakis, 591 F.2d 121, 126-27 (1st Cir. 1979). Close analysis of this regulation demonstrates that it also provides no support for the conclusion of the Court of Appeals.

25/ The regulation, now rewritten and recodified at 42 C.F.R. § 440.230 (1978) and amended subsequent to recodification, 43 F.R. 57253 (Dec. 7, 1978), provides that:

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount and duration of each service that it provides.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c)(1) The medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(2) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

HEW explained the December amendment as follows:

(footnote continued)

First, the regulation must be read against the background of the statute upon which it is based and the objectives which the Congress meant to achieve through the authorizing legislation. As previously discussed, neither the statute nor its legislative history justifies the conclusion that states are required to incur expenditures as medical assistance for all "medically necessary" health care services. Second, the regulation imposes only three requirements upon participating states: (1) a state plan for medical assistance must "specify the amount and duration of each service" for which the state will incur expenditures as medical assistance; (2) a state plan, if it includes a "service," must include it "in amount, duration

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(footnote 25 continued)

SUMMARY: This document corrects 42 C.F.R. 440.230, sufficiency of amount, duration, and scope, by reinserting two phrases omitted from the September 29, 1978, (43 FR 45176) publication of the rewritten and reorganized Medicaid regulations. The omission of these phrases was not intended to be a policy change. However, several commenters expressed concern that these omissions have been construed as a policy change restricting a State's authority to decide what medical assistance will be covered under the State Medicaid plan. In order to avoid further misunderstandings, § 440.230 is being amended as set forth below.

EFFECTIVE DATE: December 8, 1978.

43 F.R. 57253 (Dec. 7, 1978).

and scope [sufficient for it reasonably to] achieve [its] purpose"; and (3) a state "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."

The first requirement is merely a formal one designed to prescribe the minimal written content of a state plan. The second requirement imposes what is best considered an anti-waste restriction: if a state chooses to include a "service," it must include it to a sufficient extent to assure that it "reasonably achieve[s]" its purpose. For example, if a state includes benefits for inpatient hospital services related to the treatment of infectious disease, it cannot make these benefits so minimal (say, limited to two days of hospitalization) that few if any patients could be expected to recover from their illness before they would either have to be discharged or begin paying for additional hospital stay days themselves. For obvious reasons, such a benefit would have little value to recipients and might promote highly undesirable provider attitudes, contrary to Congress's explicit desires. 26/

Finally, the third requirement is by its very terms designed solely to prevent states from denying benefits to an individual "recipient" — already otherwise determined

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26/ See 1 U.S. Code Cong. & Admin. News at 2017 (1965).

to be eligible for medical assistance—because of the recipient's particular medical situation. Thus, a state may not include a provision in its state plan which purports to authorize a social worker to deny benefits to a Medicaid recipient simply because the recipient needs, say, extensive thoracic surgery which would entail a long hospital stay and post-operative recovery in a skilled nursing facility for several months, assuming, of course, that thoracic surgery in general is a "required service" included in the state plan. Simply put, this requirement has no applicability to a state plan provision which removes from the list of "services" a specific type of surgical service, thus precluding providers of health care services from seeking reimbursement from the state for the cost of any (or some) such services which they provide to all Medicaid recipients. Such a future-oriented, across-the-board elimination of a "service" from a state plan for medical assistance is in all respects consistent with Congressional intent. 27/

27/ The final paragraph of the regulation should be read as a qualification of the broad prohibition contained in paragraph (c)(1), not as an independent provision. That is, paragraph (c)(2) permits a state to limit benefits to an individual recipient for appropriate reasons, e.g., a determination that further benefits are not "medically necessary." The paragraph does not constitute an exclusive list of appropriate limits; nor does it impose any duty upon participating states.

The amici states submit that this review of title XIX's statutory and regulatory requirements should establish as a matter of law that the Illinois' state plan for medical assistance conforms to the requirements of §1902 of the Act, 42 U.S.C. §1396a (1976). The conclusion of the Court of Appeals to the contrary is an unjustifiable one, and this Court should not ratify it.

CONCLUSION

For the reasons set forth above, the Court should determine that Illinois' state plan for medical assistance conforms to the requirements of title XIX of the Social Security Act.

Respectfully submitted,

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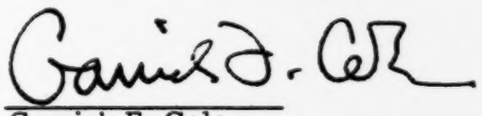

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